

### ***Hyder and Morrow Respond***

We welcome the letter from colleagues working in Pakistan and appreciate their interest in the application of burden of disease methods.<sup>1</sup> The points raised by Nanan and White are important and deserve further explanation and careful consideration. The use of com-

posite indicators, such as HeaLYs and DALYs, to provide a common denominator for use in burden of disease analyses involves issues of measurement (incidence, disability, mortality, and life expectancy) and issues of value (life lived at different ages, life lived at different times, and how life is used [social-economic productivity]).

The choice of a particular value depends on the purpose of the analysis.<sup>1</sup> For international comparisons, the use of current “best” life tables would seem the clear choice; otherwise, populations with short life expectancies would appear to lose less than those with long life expectancies and therefore would command fewer resources to improve their health status. A case might be made for use of local life tables for resource decisions if there were differential benefits for specific interventions when there were important differences in disease patterns. However, empirical studies have shown that even large differences in the life tables used make little difference in relative cost-effectiveness decisions.<sup>2</sup>

The choice of disability-severity weights is a choice in the HeaLY method, and there are none available for Pakistan. The use of the Ghana weights was therefore deemed a good starting point. Specific conditions may deserve special consideration in each country; for example, in Ghana, infertility in a woman was a devastating loss, whereas it might not be so serious else-

where.<sup>3</sup> Our article was intended as a starting point to stimulate further work in this area.

We agree that we compared different methods for different populations, but we went to some length to explain the differences in an effort to draw useful and reasonable conclusions. At present this is the best information available.

We agree on the need to further focus this approach for priority setting, and we believe this is the main justification for use of a composite single summary indicator; there are, however, many ways to do this, depending on the objective. What is clear is that burden of disease estimates can be used for intervention planning and to inform policy decisions.<sup>3</sup> The assessment of healthy life lost allows for important nonfatal health outcomes to be rightfully counted in such decisions.

Measurement of health inequalities in a population is certainly critical for the development of health policies and interventions.<sup>4</sup> Recent proposals have focused on specific indicators for such a purpose—measures of inequalities and measures of spread. HeaLYs disaggregated by sex, age, social status, ethnicity, vulnerability, and other relevant characteristics will be able to provide information on inequalities within a population or over time.

Finally, we reiterate that the use of any method depends on the objective at hand and on the quality of data available. The biggest

challenge for health policy and planning in countries such as Pakistan is the lack of good data. It is time to confront that challenge. □

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